

***CABINET POLICY: Insurance does not go into effect until the
Kentucky Volunteer Insurance Program has received premium.***

VOLUNTEER INSURANCE PROGRAM

2005-2006

Please furnish **ALL** information as requested below. Please **TYPE** or **PRINT**.

NAME: _____ PHONE #: _____
Last First M.I. Include area code

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____
dd/mm/yyyy

ADDRESS: _____
Street City Zip

DESCRIPTION OF VOLUNTEER ACTIVITY: _____

VERIFICATION FROM SUPERVISOR: _____
Signature of Supervisor

_____ Title

_____ Phone #

BENEFICIARY OF THE INSURED:

NAME: _____

ADDRESS: _____

SOCIAL SECURITY #: _____

PHONE #: _____

	<i>Rate</i>	<i>Coverage</i>
Accident:	<u>\$ 5.25</u>	<u>\$ 5.25</u>
Excess Automobile Liability:	<u>\$ 5.25</u>	<u>\$</u>
Handling fee to cover the cost of processing: (postage, copying, membership fee, etc.)	<u>\$ 6.00</u>	<u>\$ 6.00</u>
TOTAL AMOUNT ENCLOSED:	<u>\$16.50</u>	<u>\$</u>

Coverage will expire on June 30, 2006 regardless of the effective date. Fees will not
the year. **PLEASE DO NOT SEND CASH.** Make your check or money order payable
application to:

Kentucky Volunteer Insurance Program
KCCVS 3W-F
275 East Main Street
Frankfort, KY 40621

Please allow approximately two weeks for your application to be processed
and a receipt mailed verifying your coverage.

Contact KCCVS at 800-239-7404 regarding coverage information.
E-mail address: kccvs@ky.gov

iring
mail

FOR OFFICE USE ONLY:

Receipt Date:

Signature:

Please feel free to copy this form and share it with volunteers who may not have received it.

